A REPORT
TO THE
MONTANA
LEGISLATURE

PERFORMANCE AUDIT

Home and Community Based Services Waiver Program

Department of Public Health and Human Services

AUGUST 2010

LEGISLATIVE AUDIT
DIVISION

10P-05

Performance Audits

Performance audits conducted by the Legislative Audit Division are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Members of the performance audit staff hold degrees in disciplines appropriate to the audit process. Areas of expertise include business and public administration, journalism, accounting, economics, sociology, finance, political science, english, anthropology, computer science, education, international relations/security, and chemistry.

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August 2010

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the Home and Community Based Services Waiver Program managed by the Senior and Long Term Care Division within the Department of Public Health and Human Services. The department manages the federal Section 1915(c) Medicaid waiver program designed to help elderly and physically disabled persons remain in a home or community-based setting instead of being placed in a nursing facility.

This report provides the Legislature information about program services, waiver cost-effectiveness, oversight, and financial accountability of program funds. The report includes recommendations for improving processes for enrolling persons into the program, enhancing program oversight of contractors, and expanding financial controls.

We wish to express our appreciation to Department of Public Health and Human Services personnel for their cooperation and assistance during the audit.

Respectfully submitted,

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MONTANA LEGISLATIVE AUDIT DIVISION

PERFORMANCE AUDIT

Home and Community Based Services Waiver Program

Department of Public Health and Human Services

AUGUST 2010 10P-05 REPORT SUMMARY

The Home and Community Based Services Waiver Program is generally a less costly alternative to nursing facility care; however, its more than 2,200 elderly and physically disabled clients would be better served by effective waiting list management, increased oversight of contractors, heightened financial accountability, and other improvements.

Context

The Department of Public Health and Human Services (DPHHS) waiver program is designed to help elderly and physically disabled persons remain in their homes instead of being placed in a nursing facility. Individuals must meet Medicaid eligibility requirements and nursing home level of care standards to participate. The program operates under an agreement with the federal Centers for Medicare and Medicaid Services. DPHHS must comply with the agreement to remain eligible for nearly $25 million annual federal Medicaid funds.

The program provided waiver services to nearly 2,300 persons during fiscal year 2009. The program is generally limited to the number of slots that DPHHS can fund based on legislative appropriations. The following table illustrates the number of clients and growth in the waiver program over the past four fiscal years.

Home and Community Based Services Waiver Program Slots
Fiscal Years 2006 through 2009

Fiscal Year	Expansion Slots	Nursing Home Transition Slots	Total Slots	Total Clients Served
2006	45	15	1503	1938
2007	56	14	1573	2046
2008	79	44	1696	2205
2009	23	46	1765	2290

Source: Department of Public Health and Human Services.

Waiver expenditures cover a wide array of services such as case management, homemaker services, adult day health, respite care, nursing services, and environmental modifications. Total expenditures for fiscal years 2008 and 2009 were over $62 million. General Fund expenditures for the waiver program for that period were almost $14 million, or approximately 22 percent of total program expenditures.

DPHHS contracts with a firm to perform eligibility screening to assess whether applicants require a nursing home level of care. The department also contracts with case management teams to manage and oversee services provided to waiver recipients. Case management teams are located throughout the state and are responsible for identifying services recipients need and ensuring those services are provided. The department is responsible for oversight of all contractors to ensure contract obligations are met, program policies are followed, and to verify recipients' service needs are provided.

Our overall objective was to evaluate the efficiency and effectiveness of the waiver program. To accomplish this, we reviewed case files, interviewed department personnel and members of case management teams, evaluated program controls, and examined financial records.

Results

Audit work found the waiver program is generally a less costly alternative to nursing facility placement. While the waiver program has policies and procedures for managing program operations, department personnel and contractors did not always comply with these. Audit work also identified issues with how DPHHS allocates and manages program resources and assures financial oversight of program expenditures.

Audit work identified three primary areas in which waiver program improvements can be made – client waiting list management, program and management controls, and financial accountability. Recommendations to DPHHS address the need to:

- Comply with administrative rules regarding eligibility of nursing home residents for waiver services.
- Improve allocation of waiver slots for eligible waiver applicants among case management teams.
- Ensure case management teams submit accurate waiting list information.
- Review case management team activities in accordance with federal agreements and department policy.
- Improve the client satisfaction survey process.
- Conduct oversight review of level of care needs assessments completed by a contractor.
- Improve the process for selecting clients for quality assurance reviews.
- Strengthen financial controls by requiring more detailed provider information on bills and undertaking steps to review claims submitted for payment.

Recommendation Concurrence	
Concur	8
Partially Concur	0
Do Not Concur	0

Source: Agency audit response included in final report.

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Chapter I – Introduction

Introduction

The Department of Public Health and Human Services (DPHHS) manages a Medicaid waiver program intended to provide cost-effective, community-based alternatives to nursing facility placements for elderly and physically disabled persons. This program is the Home and Community Based Services Waiver Program (program). While the State Medicaid Plan is an entitlement for all persons that meet Medicaid eligibility requirements, the waiver program has limited enrollment based on funds appropriated by the state legislature. The Legislative Audit Committee prioritized a performance audit of this program.

Audit Scope

Audit scope focused on the department's waiver program activities directly related to oversight and monitoring of program activities. We did not examine processes for determining whether enrolled clients met Medicaid financial eligibility or nursing facility level of care requirements for program participation.

Audit Objectives

Our overall audit objective was to evaluate effectiveness of the department in administering the waiver program. In order to determine this, we developed the following specific audit objectives:

1. Determine whether the program provides a less costly alternative for supplying services to elderly and disabled persons who would otherwise require placement in a nursing facility.
2. Determine whether the program has a process for prioritizing clients for placement in available program "slots" that provides assurances that clients enrolled in the program are most in need of services.
3. Determine whether the program has management controls in place for effectively monitoring the quality of services provided to waiver clients.
4. Determine effectiveness of fiscal controls for verifying services billed to Medicaid are provided to waiver program clients.

Methodologies

To answer the audit objectives, we conducted the following audit work:

- Interviewed six case management teams in four communities
- Reviewed 53 files at five case management teams
- Interviewed five regional program officers in four waiver program areas

- Reviewed the department's Quality Assurance Management System (QAMS)
- Reviewed program fiscal data for fiscal years 2008 and 2009
- Interviewed other DPHHS Medicaid waiver program managers
- Interviewed the Centers for Medicare and Medicaid Services (CMS) liaison assigned to Montana
- Reviewed program documentation, including policies and procedures
- Interviewed other states' Medicaid waiver program staff
- Interviewed representatives of other organizations and stakeholders, including the state ombudsman for Montana
- Compared Montana's program to a sample of other states
- Analyzed waiver program Medicaid expenditures to evaluate fiscal controls
- Reviewed CMS documentation pertaining to renewal of the waiver agreement

Review of a Sample of Files

In order to meet our audit objectives, we reviewed a random sample of client files maintained by case management teams (CMTs). The department contracts with CMTs to provide case management services to program clients. CMTs are located in various communities throughout the state. To ensure we reviewed a broad-based assortment of client files, we selected a random sample of program clients from enrollment data maintained by the department in its Medicaid Management Information System (MMIS). DPHHS does not collect specific information on clients served by the program. Instead, each CMT maintains its own client records including required program forms, level of care assessments, case notes, and care plans. Consequently, we traveled to a sample of CMT offices to review related documentation. While reviewing file documentation, we also reviewed department monitoring of CMT activities that department staff document through the use of annual review assessments.

Report Organization

The remainder of this report includes chapters addressing each of our audit objectives and is summarized as follows:

- Chapter II provides background information about the program
- Chapter III examines whether the waiver program provides a less costly alternative to nursing facility placement
- Chapter IV addresses managing client waiting lists throughout the state
- Chapter V discusses the program's system for ensuring statewide quality assurance
- Chapter VI discusses financial accountability controls over use of program funds

Chapter II – Background

Introduction

This chapter provides background information about the Montana Medicaid program and the Home and Community Based Services Waiver Program (program). The waiver program is administered by the Senior and Long Term Care Division at the Department of Public Health and Human Services (DPHHS).

Montana Medicaid Plan

Medicaid is a federal and state funded program designed to assist individuals with limited income and resources. When an eligible Medicaid recipient has no other means to pay for health services, Medicaid will provide partial or full payment. All persons who meet Medicaid eligibility requirements are entitled to receive Medicaid benefits for allowable expenditures.

Home and Community Based Services Waiver Program

The department administers a federal Section 1915(c) Medicaid waiver program designed to help elderly and physically disabled persons remain in their homes instead of being placed in a nursing facility – either a nursing home or a hospital. This waiver is called the Home and Community Based Services Waiver. To be eligible for waiver program services a person must meet three basic criteria:

- Is 65 or older or, if under 65, is certified as disabled by the Social Security Administration
- Meet income guidelines for Medicaid program eligibility
- Meet a level of care criteria for placement in a nursing home or hospital

Typically, persons enrolled in the program also receive State Medicaid Plan services. However, services authorized under the State Medicaid Plan are restricted to certain types of services. The waiver program allows expenditures for services not authorized by the State Medicaid Plan. Examples of services authorized by the waiver program but not the state plan include:

- Case management services
- Homemaker services
- Adult day health
- Respite care
- Nursing services
- Transportation

- Adult residential care in a personal care or assisted living facility, or in an adult foster home
- Services provided by a family member

The program also authorizes environmental modifications to an individual's home or vehicle to enable them to remain in the community. Examples of environmental modifications include:

- Installing access ramps to a residence
- Remodeling a residence to allow persons to access rooms with a wheelchair
- Installing grab bars in bathrooms
- Installing mechanical lifts to allow recipients to access a vehicle

Program Contracts for Case Management Services

The program contracts with 17 case management teams (CMTs) for case management services and teams are located throughout the state. Case management services are provided by Area Agencies on Aging programs and nonprofit organizations. One or more case management teams are located in the communities illustrated in Figure 1.

Figure 1
Location of Case Management Teams
Home and Community Based Services Waiver Program

Source: Compiled by the Legislative Audit Division from Department of Public Health and Human Services records.

Area Agencies on Aging tend to provide services primarily to elderly clients. However, if needed, Area Agencies on Aging will also serve physically disabled persons. If there is more than one team in the area, at least one team will serve both types of clients.

Case Management Activities Cover Wide Range of Services

Case management services include:

- Assessing client needs
- Developing appropriate plans of care that allow clients to remain in the community
- Arranging for provision of services by agencies, family members, and volunteers
- Monitoring delivered services and making changes as needed
- Reassessing client plans of care and services needed every six months or more often, if needed
- Managing costs to ensure client expenditures remain within prior authorized amounts
- Coordinating and overseeing direct care services provided to clients
- Negotiating rates for provider services

For fiscal year 2009, the department contracts with case management teams stipulated a per diem rate of approximately $8.19 per client. DPHHS contracts also allow case management teams to be paid an hourly rate of $55 for some case management activities. Interviews indicated case management teams rarely provide services at the hourly rate. A case management team might request reimbursement at the hourly rate for costs associated with establishing services for clients who receive limited one-time services but are not continued on a team's caseload. Table 1 provides information on the department's costs for case management services in fiscal years 2008 and 2009.

Table 1
Expenditures for Case Management Services
Fiscal Years 2008 and 2009

Fiscal Year	Expenditures
2008	$4,990,979
2009	$5,343,872

Source: Department of Public Health and Human Services.

Case Management Teams Manage Program Service Expenditures

The department allocates each CMT a fixed number of slots to serve clients through the waiver program. The department uses slots to estimate and control program

expenses and establishes a specific cost per type of slot. Each CMT is granted an annual budget for their respective caseloads and CMTs are required to provide services within the constraints of their budgets. The annual budget depends on the number and types of slots allocated to the individual CMT. The two most common types of slots are basic care and adult residential. Basic care slots provide services that allow clients to remain in their home and are generally allocated at $17,500 annually. Adult residential slots are commonly placements in assisted living or similar facilities and are generally allocated at $27,000 annually. CMTs may exceed these allocations, but require DPHHS authorization if expenditures will exceed $29,000.

High-Cost Slots Managed by DPHHS

There is another type of slot, heavy care, which is funded by this program. Heavy care slots are normally managed by department staff, but local CMTs might be responsible for these slots in areas where there are a large number of heavy care clients. Heavy care slots may exceed $250,000 annually due to a client's need for more extensive services. These services could include 24-hour nursing care, ventilator support, etc. CMTs responsible for managing heavy care slots will normally have regular communication with department managers.

Program Slots Have Increased

Unlike the Montana Medicaid program, which is an entitlement program for reimbursing eligible medical expenses, the waiver program is an agreement with the federal Centers for Medicare and Medicaid Services (CMS), which allows DPHHS to restrict the number of participants that may be enrolled in the program. The program is generally limited to the number of slots which DPHHS can fund based on legislative appropriations. The number of program slots has increased in recent years through several mechanisms. First, the legislature increased program funding available for physically disabled and elderly persons during the 2009 and 2011 bienniums. Second, the program expanded the number of available slots through a process the department refers to as Nursing Home Transitions. This process is used to identify individuals living in nursing facilities who might be candidates for a community-based placement with waiver program services. Table 2 provides information on the number of waiver slots including expansion slots for fiscal years 2006 through 2009. The table also provides information on the number of clients receiving services through the program.

Table 2
Home and Community Based Services Waiver Program Slots
Fiscal Years 2006 through 2009

Fiscal Year	Expansion Slots	Nursing Home Transition Slots	Total Slots	Total Clients Served
2006	45	15	1503	1938
2007	56	14	1573	2046
2008	79	44	1696	2205
2009	23	46	1765	2290

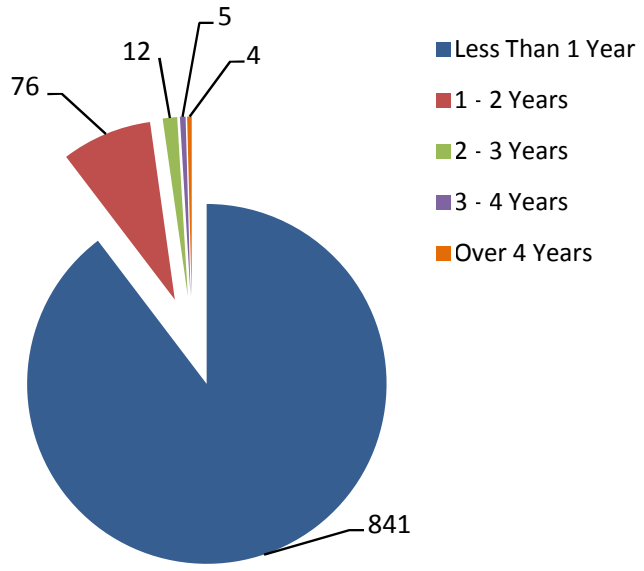
Source: Department of Public Health and Human Services.

Note that the table shows the total number of clients served exceeds the total number of slots. This occurs for several reasons. First, some clients remain in the program for less than the full year, which allows another client to be enrolled for the remainder of the year. Second, some clients require limited assistance, such as minor home modifications to improve stability, which allows a portion of the slot to be used by another client. For example, if a person in a basic slot needs services that cost $12,000, the remaining dollars for the basic slot ($5,500) can be used to provide additional services to another person or be used on one-time needs, such as building an access ramp to a home. On average, DPHHS estimates each waiver slot serves approximately 1.3 people.

Potential Clients May Be Placed on Waiting List

Although the Legislature and DPHHS have expanded the waiver program, the demand for slots still exceeds the number of available slots. According to DPHHS documentation, there were 454 individuals on waiting lists as of June 30, 2009. Once a person is determined eligible for the program, CMTs complete a department-developed assessment tool. The assessment tool evaluates a person's risks and needs based on a variety of factors that generally rate the immediacy of services to prevent institutionalization. Persons with higher scores are considered to have greater need for program services and are more likely to be enrolled in the program more quickly. It is possible that persons with low waiting list scores may have to wait for extended periods, or may not be able to receive services because of persons with higher scores. Our analysis of waiting list information indicated the average length of time a person was on a waiting list during fiscal year 2009 was 146 days. The number of days persons were on the waiting list ranged from 0 days to nearly six years. Figure 2 illustrates the number and length of time clients were on the waiting list in fiscal year 2009.

Figure 2
Number and Length of Time Clients on Waiting List
Fiscal Year 2009



Source: Compiled by the Legislative Audit Division from Department of Public Health and Human Services records.

Waiver Program Funding

The legislature appropriates funding for the DPHHS waiver program. Table 3 provides funding information for the program for fiscal years 2008 and 2009.

Table 3
Home and Community Based Services Waiver Program Funding
Fiscal Years 2008 through 2009

	FY 2008	FY 2009
General Fund	$7,773,375	$6,162,975
State Special Revenue	$1,447,528	$1,837,192
Federal Special Revenue	$20,135,385	$24,654,884
Total	**$29,356,288**	**$32,655,051**

Source: Compiled by the Legislative Audit Division from SABHRS.

Renewal of Medicaid Waiver Agreement

The waiver agreement is currently being reviewed by CMS. The quality review is being conducted to determine if DPHHS is providing assurances it complies with waiver agreement components and to assess waiver performance activities. The state must demonstrate compliance by the time the renewal application is due to CMS. The current program expires in 2011 and DPHHS is in the process of working with CMS on demonstrating compliance and renewing the waiver program.

Chapter III – Waiver Cost-Effectiveness

Introduction

Our first audit objective was to evaluate whether the Home and Community Based Services Waiver Program (program) provides a less costly alternative to nursing facility placements. According to the waiver agreement between the department and federal government, individuals enrolled in the waiver program must meet the level of care for placement in a nursing home or hospital. Throughout this chapter, we use the term nursing facility, which includes nursing homes and hospitals.

To examine the costs of the waiver program compared with nursing facility placements, we examined and compared department expenditure data for people enrolled in the program with established nursing home rates and costs of hospital placements. We also conducted reasonableness tests in order to verify accuracy of the department's cost figures reported to the federal government. Direct costs comparisons are difficult since the bundle of services provided to Medicaid recipients under the waiver program and nursing facilities differs. A key difference is waiver program clients pay their own living expenses while Medicaid nursing home rates include payment for room and board. This chapter provides information about the differences in costs between nursing facilities and the department's waiver program and concludes on whether the waiver program provides a less costly alternative to nursing facility placements.

Costs for Waiver Program

Costs for persons enrolled in the waiver program can vary widely, ranging from several hundred dollars for a one-time service to more than $250,000 per year. Persons who are considered as meeting nursing facility level of care may be able to remain in their homes with relatively inexpensive environmental modifications or other services. For example, installation of grab bars in a bathroom or a ramp to access a residence may be sufficient to allow a person to maintain sufficient mobility to remain in their home. Conversely, some persons who might be served in a hospital may require extensive nursing care and other services to maintain a community-based placement.

Waiver Placements Generally Less Costly Than Nursing Facility Placements

Our file review of 53 client files indicated the average cost for a waiver program placement was approximately $19,055 for an initial annual plan of care cost in fiscal years 2008 and 2009. Annual plans of care are developed for each program client that outline services to be provided and contain estimated cost of providing the services. In some instances, costs of plans of care increased due to the need for more care and

services. In other instances, costs decreased because initial costs included one-time expenditures, such as environmental modifications to a residence. This average was likely higher due to several cases with high cost placements.

We also reviewed actual annual client expenditures for fiscal year 2009. Waiver client expenditure data was extracted from the Medicaid Management Information System (MMIS). Review of MMIS data for fiscal year 2009 indicated average expenditures for clients was $13,744. The highest cost for a 2009 placement was approximately $252,500. This range of costs does not include other Medicaid costs for services provided under the State Medicaid Plan. Additionally, clients enrolled in the waiver program also must pay for their own room and board, a cost Medicaid incurs if a person is placed in a nursing facility.

We also reviewed the daily Medicaid rates for nursing homes. Nursing home Medicaid rates are based on costs and nursing home resident acuity levels. The average Medicaid per diem reimbursement rate for nursing homes for fiscal year 2009 was $158.78, or approximately $57,955 annually. This does not include other Medicaid expenditures for services or care not covered by the nursing home rates. Examples of Medicaid costs not included in the nursing home rates are items or services such as prescription medications, physician care, therapy, and some medical supplies.

In addition, we reviewed costs of nursing facility placements, which includes nursing homes and hospitals. Department documentation indicates the estimated annualized costs for nursing facility placements to be $75,211, which includes expenditures for facilities with higher rates due to the level of services provided, such as hospital placements.

CMS Requires Cost Neutrality for Program Costs

While the goal of the program is to provide care and services to persons in a less costly community-based setting, expenditures for some program clients are considerably more costly than placement in a nursing facility. They include persons who require extensive nursing care, may be dependent on ventilators for breathing, or have sustained serious traumatic brain injuries. According to Olmstead v. L.C., (527 US 581 (1999)), a U.S. Supreme Court case, a state is required to place individuals with disabilities in community settings when it is appropriate for the individual's treatment, not opposed by the individual, and the placement can be reasonably accommodated given state resources. The department's preference has been to not deny a person a community-based placement if it is based solely on being more costly than a nursing facility placement.

In order for the waiver agreement to be approved by the Centers for Medicare and Medicaid Services (CMS), the state must demonstrate to the satisfaction of CMS the waiver is cost neutral during each year the waiver is in effect. According to CMS, cost neutrality means that on an average per capita basis, the cost of providing home and community based services will not exceed the cost of care for the identical population in a nursing facility. To demonstrate compliance with the cost neutrality portion of the waiver agreement, the department submits a "372" report that provides CMS with information about the waiver program, and includes a comparison of waiver program and nursing facility expenditures. While we did not audit how DPHHS extracted cost information, we did verify the formulas used for calculating cost-neutrality appeared correct. Our review of DPHHS's 372 report provided to CMS in 2007, the most recent report available, indicated the average cost for waiver placements, including state plan Medicaid costs for persons in the program, was $23,004. The average cost for nursing facility placements, including other state plan Medicaid costs, was $78,324.

Analysis shows that the average costs of services provided to waiver clients ranged from $13,744 to $19,055, depending on the data used. Nursing facility placements ranged from an average of $57,955 to $75,211. Serving clients through the waiver is typically less costly than nursing facility placements. This is due primarily to the fact that these clients generally require less care and are responsible for their own room and board costs. Costs of caring for individuals in nursing facilities are greater since they require some level of 24-hour care and costs include room and board. Based on information provided by the department and confirmed by our analysis, the waiver program generally provides a less costly alternative to nursing facility placements.

CONCLUSION

The Home and Community Based Services Waiver Program generally provides a less costly alternative to nursing facility placements.

Program Expansion

The legislature expanded the waiver program by increasing funding, thereby allowing DPHHS to increase the number of program slots available. The department also expanded the waiver program by creating a project to identify specific nursing home patients who can be served via the waiver program and transition them, and each client's associated Medicaid-funding, into the waiver program.

Nursing Home Transition Is Used to Expand Available Slots

Nursing Home Transition focuses on identifying nursing home patients, under the age of 65 and disabled, who would be able to transition out of a nursing home environment into the local community if given the proper resources and assistance. Although the focus is under age 65, patients of any age can be transitioned out. If a person is able to transition into the local community, those Medicaid funds that supported them in a nursing facility are reallocated into the waiver program to pay for services. According to the department, once the person leaves the waiver program, the nursing home funds remain as another source of program funding. Table 2, on page 7, identifies the number of nursing home transition slots that have been created by DPHHS since fiscal year 2006.

DPHHS Does Not Comply With Administrative Rule

While the Nursing Home Transition process has been in place for at least 10 years, administrative rules and program policies do not allow persons residing in nursing facilities or hospitals to be considered for enrollment in the waiver program. ARM 37.40.1408, provides enrollment criteria and states a person is qualified to be considered for enrollment in the program if the person "does not reside in a hospital or nursing facility." Similarly, department policy 401 states one criteria for enrollment in the program is that a person not reside in a hospital or nursing facility. Since DPHHS is actively enrolling individuals residing in nursing facilities into the waiver program, DPHHS is not in compliance with administrative rules.

According to program management, they have interpreted the administrative rule to mean that persons could not receive services while residing in hospitals or nursing facilities. However, we believe the administrative rules and policy clearly state that persons residing in hospitals or nursing facilities are not eligible for enrollment in the program. DPHHS should comply with administrative rules and program policy that specifies persons residing in hospitals or nursing facilities cannot be considered eligible for program participation.

RECOMMENDATION #1

We recommend the Department of Public Health and Human Services comply with administrative rules that contain enrollment criteria specific to individuals residing in a hospital or nursing facility and if necessary, reevaluate existing administrative rules for applicability.

Allocation of Program Slots to Eligible Persons

This chapter discussed the limited number of slots and legislative and program efforts to expand the program and the number of slots available. With a limited number of slots available, some clients are placed on waiting lists until an opening in the program occurs as slots become available. Chapter IV presents information on DPHHS management of waiting lists and recommendations for improving waiting list administration.

Chapter IV – Waiting List Priorities

Introduction

Our second objective was to determine whether the department has a process for prioritizing clients for placement in available waiver program slots that provides assurances clients enrolled are most in need of services. As mentioned in the previous chapter, the number of program slots available for people desiring waiver services is limited. The program currently has no formal process for identifying where or how many slots should be allocated to serve the needs of eligible clients. This chapter presents information about how the program prioritizes clients for enrollment into the program and makes recommendations for improving the prioritization process.

DPHHS Uses Risk and Needs Based Methodology

The Department of Public Health and Human Services (DPHHS) uses an assessment tool to evaluate the needs of a waiver applicant and the corresponding risk that an applicant may need placement in a nursing facility or hospital if services are not provided. Case Management Teams (CMTs) are responsible for completing an assessment for each person referred to them for services. The assessment tool CMTs must use is specified in program policy. The assessment tool includes factors such as:

- Is the applicant at risk of medical deterioration without services?
- Does the applicant have a cognitive impairment?
- Is there a need for more formal (paid) services?
- Are the existing supports (family/friends) sufficient at this time?
- Is there a need for adaptive aids or environmental modifications?

The minimum score a person can receive is nine and the maximum score is 25. Each assessment factor is rated on a score of one to three based on the severity of the situation or need for services. For example, when scoring for cognitive impairment, a score of one indicates a person is aware and capable of making good decisions. Conversely, a score of three would reflect a person is unable to make good decisions and cannot function independently without supervision and/or constant reminders. An assessment must be completed within 60 days of a person being referred to the waiver program for services. The resulting score determines whether and/or when a person is enrolled in the program, with a higher score giving persons a higher priority for a slot. Department policy also requires CMTs to submit a quarterly list of all client waiting list scores for program review. Interviews with CMT personnel, department personnel, and program documentation indicate CMTs comply with these requirements.

Improving Allocation of Program Slots Among CMTs

The waiver program does not have formal objective criteria for examining the allocation of slots and reallocating slots based on area or community needs. Review of the allocation of slots indicates slots generally appear to be distributed in a proportional manner, with some variation. Smaller communities tended to have 1-6 percent of the allocated slots, and larger communities tended to have 9-13 percent of the allocated slots. While this generally reflects an underlying assumption that larger communities are more likely to have more demand for available slots, it is not based on any formal objective criteria or factors. Also, it does not account for actual or potential factors such as numbers of clients on waiting lists, average wait time on waiting lists, or relative waiting list scores among case management teams.

Technical guidance provided by the Centers for Medicare and Medicaid Services (CMS) sets requirements and conditions for allocation of slots among CMTs. One requirement is that slots be based on objective criteria or factors. Second, CMS requires that individuals have comparable access to services across geographic areas. CMS cited several examples of criteria for allocating waiver slots, including population of each area, other demographic factors such as aged population, assessed need for waiver services by area, or some combination of the above.

Our review of waiting list data submitted by CMTs to the program identified wide variations in waiting list data. Examples of variations included:

- One CMT had 79 persons on its waiting list and 63 total slots. Another in a similarly populated area had a waiting list of seven clients, but was allocated 68 total slots.
- One CMT accounted for 16 percent of all persons on waiting lists statewide while another CMT accounted for only four percent.
- Ability of persons to move from a waiting list to receiving services varied among CMTs. While 72 percent of clients assigned to one CMT moved from waiting list status to receiving requested services, only 14 percent did in another area.
- The average days on a waiting list varied significantly among CMTs, ranging from 65 to 336 days. The statewide average number of days clients were on waiting lists was 174 days.

We also noted the potential for variations in waiting list scores needed for eligible persons to receive program services. For example, in areas with fewer persons on waiting lists, persons with lower waiting list scores might receive a slot with a lower score than those living in areas with longer waiting lists. Thus, individuals with higher needs are not enrolled in the program.

DPHHS Has Not Developed Formal Criteria for Allocating Slots

DPHHS should develop formal criteria or factors for allocating slots among CMTs. When expansion slots have become available, program personnel attempt to distribute those expansion slots relatively evenly among CMTs to allow expansion opportunities, rather than based on demographics, needs for services in an area, or other objective factors.

RECOMMENDATION #2

We recommend the Department of Public Health and Human Services develop and implement formal criteria for allocating Home and Community Based Services Waiver Program slots among case management teams.

Improving Accuracy of Waiting List Data Provided to DPHHS

DPHHS policy requires case management teams to submit electronic quarterly reports of individuals on their respective waiting lists. Quarterly reports contain data such as client names, wait list scores, dates placed on and removed from wait lists, and disposition. Policy also requires CMT's to enter the score the individual received on the Waiting List Tool. According to department policy, this is to allow both CMTs and program personnel access to information about the waiting list. However, current data has limited value for program monitoring of CMT waiting lists. Our review of waiting lists also indicated substantial instances of inaccurate data.

DPHHS created a database system for CMTs to record information about consumers placed on waiting lists including demographics, services needed, and waiting list scores of individuals eligible for enrollment into the program. The department's database generates quarterly reports. However, CMTs have developed their own waiting lists. According to DPHHS personnel, CMTs are accurately scoring applicants on their own waiting lists using the Waiting List Tool. However, audit work found waiting list scores reported by CMTs on the department's database contained inaccuracies. For instance, of 1,264 people on the fiscal year 2009 waiting list, 56 percent of applicants had a reported waiting list score of zero. Some of the individuals with a reported score of zero were approved for Medicaid waiver assistance. The scoring tool is designed to prioritize each applicant's needs. Lack of accurate waiting list information limits the ability of department staff to make decisions about where to allocate additional

program slots when they become available. The lack of information also limits program management and staff's ability to:

- Ensure compliance with waiver agreement requirements and program policy
- Identify service needs
- Support requests for funding or resources
- Distribute caseload equitably among case management teams

DPHHS Should Require CMTs Submit Accurate Waiting List Information

In summary, DPHHS has developed a database and process for CMTs to use for recording and tracking waiting list information but is unable to use the information because of data inaccuracies. DPHHS needs to take steps to ensure CMT compliance with existing policies and procedures. Additionally, DPHHS should use the information to ensure waiver slot allocations are based on objective criteria.

RECOMMENDATION #3

We recommend the Department of Public Health and Human Services:

A. *Ensure case management teams submit accurate waiting list information as required by policy.*

B. *Analyze and utilize waiting list information to strengthen management decisions.*

DPHHS Internal Program Management Controls

In addition to management of waiting lists, DPHHS also has responsibilities for other program management activities. Chapter V will address improving internal program controls generally related to quality assurance of program activities.

Chapter V – Improving Program and Management Controls

Introduction

Program and management controls are processes developed and implemented by agencies to:

- Provide reasonable assurances program objectives will be met
- Ensure compliance with applicable laws, regulations, and policies
- Ensure efficiency and effectiveness of agency operations

Our third audit objective was to determine whether the program has management controls in place for effectively monitoring quality of services provided to clients. As a result of audit activities, we found the department has implemented many management controls to improve program management including:

- Policies and procedures to address program and contractor responsibilities
- Positive working relationships with Case Management Teams (CMT)
- Basic quality assurance processes for reviewing CMT activities

However, we found there are a number of improvements the Department of Public Health and Human Services (DPHHS) can make, which will strengthen program oversight. Areas for improvement include:

- Ensuring annual reviews of CMT activities are completed
- Improving the value and purpose of client satisfaction surveys
- Ensuring annual reviews of the Mountain Pacific Quality Health Foundation are completed
- Improving file selection criteria for annual CMT reviews

This chapter discusses these findings and makes recommendations for improving its quality assurance control systems.

Ensuring Annual Reviews are Completed

Program policy and the Home and Community Based Services Medicaid Waiver agreement with the Centers for Medicare and Medicaid Services (CMS) require the program to conduct annual reviews of case management team activities. These reviews are designed to verify CMTs comply with department policies for case management activities. The department is to complete an in-depth, full review of each team's activities at least once every three years. These full reviews include a thorough review

of representative case files and interviews of case management team clients and service providers. In the intervening years, the program can complete less intensive, minimal reviews of CMT activities. If program managers believe it is warranted, full reviews of case management team activities can occur more frequently. During audit work, we found annual reviews of at least two CMTs were not completed as required.

Failure to complete annual reviews of case management team activities can allow deficiencies to perpetuate and have the potential to reduce the number or quality of services provided to eligible clients. In one case, a full review of a CMT found significant problems with the team's handling of its client waiting list. Program management required the case management team to implement changes to their waiting list procedures. However, the department failed to complete annual reviews in the two subsequent years. When a full review of the CMT was conducted, problems were again found with waiting list procedures. Program management sanctioned the CMT by withholding allocation of additional slots until the problems were rectified. Had the department conducted its annual reviews as required by policy, the continued waiting list problems with this particular CMT might have been resolved earlier and additional eligible clients might have been enrolled in the program more quickly.

Program Managers Unaware Reviews Were Missed

Program managers state there is no process in place to notify them that DPHHS regional program officers (officers) have scheduled case management team reviews and management was unaware officers had not completed annual reviews. The program has modified its Quality Assurance Management System to allow program managers to track corrective actions following an annual CMT review. However, the system does not have a function to notify program management of required event scheduling such as annual reviews. When program management recognized required annual reviews had not been completed, reviews were scheduled for the current year. Interviews with program staff indicated staffing issues, staff turnover, and inexperience led to some of the required annual reviews not being completed. It appears program management did not recognize potential impact these staffing issues would have on ensuring compliance with the CMS waiver agreement. As indicated by the failure to complete required annual CMT reviews, without a system for notifying and tracking annual reviews, department management is unable to ensure such reviews are being completed.

RECOMMENDATION #4

We recommend the Department of Public Health and Human Services ensure annual case management team reviews are completed in accordance with policy and federal agreements.

Improving Client Survey Process

Both the waiver agreement and program policy requires annual client satisfaction surveys. The department has delegated this responsibility to CMTs. Clients or family members complete surveys and the input provided is used to ensure quality services are provided and client needs are met. We reviewed survey documents from four of the CMTs we visited and noted wide variations in the content and form of surveys, which limits their use as a management tool. For example, some surveys did not adequately address quality of services offered by contracted providers such as assisted living facilities or homemaker services. In addition, the length of surveys ranged from five to fifteen questions and the form of the surveys varied, from using a scoring scale to simple "Yes/No" responses. Survey results are not compiled or provided to program management.

Consistency Among CMTs Would Allow Department to Use Survey Responses

Client surveys can be a useful tool for gathering information about CMT case management activities, value of provided services, and program policies. If designed correctly, they can be used to evaluate both CMT and department activities. Where applicable, the department could use an online survey tool to distribute, collect and compile survey responses. This use of surveys is consistent with CMS guidance that client satisfaction surveys are a means for verifying program assurances are being met. However, the current process for surveying waiver clients is not an effective tool for evaluating performance. This is because of variations in questions asked in the survey and in the ways respondents are asked for their input. As a result, client input on quality of services provided is limited.

Wide Variations in Surveys Limits Effectiveness as a Management Tool

Program management delegated responsibility for developing survey questions, conducting the surveys, and analyzing survey responses to the contracted CMTs. Discussions with department and CMT staff indicated that CMTs received no guidance about the client survey process, such as survey development, questions that should be asked, scoring systems, or how specific responses should be tabulated. Providing a series of basic survey questions and requiring results be shared with DPHHS would allow the department to collect consistent information that could then be used to evaluate program effectiveness and identify possible improvements. Generating statewide performance data would also allow the department to meet CMS requirements for providing assurances the waiver agreement is followed, and quality services are provided to clients.

RECOMMENDATION #5

We recommend the Department of Public Health and Human Services:

A. *Standardize the client satisfaction survey.*

B. *Collect and analyze survey responses to evaluate program effectiveness and improve performance.*

Reviews of Level of Care Determinations

Before a person may be eligible for enrollment in the waiver program, they must meet a level of care standard for placement in a nursing facility. DPHHS contracts with the Mountain Pacific Quality Health Foundation (contractor) to evaluate eligibility and each applicant's level of care needs. Because the department relies on the contractor to determine a client's eligibility for program enrollment, the department agreed with CMS to "periodically review a sample of level of care determinations to ensure accuracy and consistency in the application of the level of care instrument" per the current waiver agreement. During audit activities, we found these reviews were not being conducted. In fact, department staff was unsure of when the last review was completed on the contractor, but believe it has been at least four years. Because of concerns raised during the audit and by CMS over the lack of required reviews, program staff recently conducted an audit of the contractor's level of care determinations. The department had no process in place to ensure the reviews were done.

Review of Contracted Services a Critical Management Function

Department review of the contractor's level of care determinations is essential for ensuring eligibility requirements are followed and level of care determinations are accurately and consistently applied. Reviews are needed to ensure the contractor conducts assessments that are timely, accurate, and in accordance with waiver agreement and state policies, and that the contractor complies with contract provisions. The Montana waiver agreement requires the program to complete periodic reviews of contractor activities, although the agreement does not specify the frequency of periodic reviews.

Contractor a "Gatekeeper" for Program Eligibility

When the contractor completes a level of care determination for an individual applying for program eligibility, there are two possible outcomes. The individual can be approved or denied access to the program, its funding mechanisms, and its array of services. If

the contractor is not properly determining eligibility based on level of care, the taxpayer could be funding services for an individual that is not entitled to those services or the applicant might lose the opportunity for vital assistance that allows them to remain in their community. Until the level of care determination is completed, no additional action can be taken by the program and services cannot be provided. Therefore it is imperative the program have a regular means of ensuring the contractor is accurately and consistently completing determinations.

Because of the importance of the contractor's activities to the waiver program, it is critically important department management ensure the contractor is complying with contract obligations, and accurately and consistently determining levels of care for program applicants. Ensuring the accuracy of the level of care determination is also a key part of the agreement between the department and CMS.

RECOMMENDATION #6

We recommend the Department of Public Health and Human Services define the frequency of periodic reviews of level of care assessments and ensure reviews are completed.

Improving Client Selection Process for Annual Reviews

At least every three years, CMTs are required to undergo a full review by the department. During this review, program management selects a sample of associated case files to verify and ensure compliance with program policies. According to the program officer's desk manual, selection of files is based on client lists provided by the CMT. However, there is the potential that CMT-provided client lists are not complete. If a CMT chooses to withhold a particular client's file from the list, there is the chance significant errors may not be identified during the client file review, such as:

- Incomplete intake assessments
- Detailed plans of care
- Incorrect funding calculations

During our audit activities, we selected client files to review by utilizing the department's Medicaid Management Information System (MMIS). If an individual is enrolled in the waiver program, they must be listed in MMIS before funding for case management or assistance services becomes available. Using MMIS-supplied client names ensures all enrolled clients are included in a CMT's annual review, improving

the assurance department management and staff will identify possible problems with case management activities. Use of MMIS data will also allow the program to conduct statistical sampling during CMT full reviews and determine if, over time, there are system-wide problems that need to be addressed. DPHHS could strengthen its current annual review process by extracting client information from MMIS, thereby assuring it has a complete client list to identify a sample of client files for review. This will help ensure a representative sample.

RECOMMENDATION #7

We recommend the Department of Public Health and Human Services use the Medicaid Management Information System to select a sample of client records for reviews of case management teams.

Program Financial Accountability

In addition to general program management and oversight, the department also is responsible for managing the waiver program's financial resources. Chapter VI will address improving program financial accountability.

Chapter VI – Improving Program Financial Accountability

Introduction

A government financial accountability system is intended to provide assurances public funds are used in a responsible and appropriate manner. For the Home and Community Based Services Waiver Program (program), accountability generally means services billed were actually provided, only eligible clients receive provided goods and services, and bills for goods and services are accurate. This chapter addresses the last audit objective which was to determine effectiveness of program fiscal controls for verifying services billed to Medicaid are provided to program clients.

Agencies Use Controls to Protect Financial Accountability

Agencies use a combination of controls to mitigate risks to financial accountability, such as paying for services that are not approved or necessary. The following are controls the Department of Public Health and Human Services (DPHHS) has established:

- Preauthorization of Expenditures. Before a service provider may provide services, the case management team must preauthorize allowable goods and services.
- Case Management Team Preauthorizations Limited. Case management teams may only preauthorize expenditures up to $29,000 per individual per year for services. There are lower limits for some services such as home modifications.
- DPHHS Must Approve Services in Excess of Preauthorized Limits. When projected expenditures exceed case management teams' preauthorized limits, program personnel must approve the authorizations. This control ensures case management teams keep program personnel apprised of projected client costs when expenditures are anticipated to exceed allowable amounts.

While DPHHS's processes described above help mitigate financial risks, the program generally relies on case management teams for compliance monitoring. This consists of occasional observations during home visits or interviews with clients or family members to verify services are provided. For example, if homemaker services are authorized, case management team staff will look at the general condition of the residence to determine whether the services appear to be provided. Department staff also do some monitoring to ensure services are provided and, during annual reviews, program personnel interview clients about services provided. However, these assurances generally rely on observations and interviews. Neither department staff nor case management teams examine and compare service and billing records specifically for the waiver program. For example, no one compares provider timesheets with services billed.

To examine whether existing controls were working, we used a data analysis tool to examine all waiver program claims for fiscal year 2009. Our analysis found:

- Twenty-seven sets of duplicate claims that were paid.
- Six instances where persons received more than seven services in a day. The majority of claims were for one service in a day.
- Four records where providers billed for 23 hours of services in a 24-hour period.

Because of limited provider details, we were unable to further determine whether these were legitimate anomalies or overpayments for services. We referred the information to DPHHS's Quality Assurance Division for further review and consideration.

Data Limitation Exists

Audit work indicated a data limitation exists for effectively using analysis tools as part of an effective controls system. The obstacle we encountered was DPHHS tracks data for providers, or companies that provide services, but not details regarding the individuals actually providing the services. Lack of provider details and specifics limited us from thorough testing and analysis. For example, providers are not required to report the names and/or other identifying information about individuals providing services. Lack of this information limits DPHHS's abilities for verifying services billed are reasonable and appropriate. For example, it may be reasonable and appropriate for a client to receive 23 hours of service during a 24-hour period, but for a single person to provide those 23 hours of service during that time period would be questionable. DPHHS's current billing practices do not permit that level of analysis, which is a system weakness.

Program Does Not Utilize Quality Assurance Division for Reviews

In its agreement with the Centers for Medicare and Medicaid Services (CMS), DPHHS states it will utilize the department's Quality Assurance Division to provide assurances over the waiver program's financial activities. The department's Quality Assurance Division has the ability to conduct analyses similar to the ones we did. However, the program has not requested assistance from the Quality Assurance Division. Additionally, the waiver program has also not formally identified or used other controls, such as comparing employee timesheets to services billed to provide assurances that existing controls are working as intended.

DPHHS Should Enhance Waiver Program Controls

Although the department has implemented some controls, current system weaknesses increase the financial risk to DPHHS. CMS is currently reviewing Montana's Home and Community Based Services waiver for compliance with the waiver agreement and also identified financial accountability as an area for program improvement. Improving controls should consist of requiring service providers to include more details on billing statements, such as which employees are actually providing services to clients. In addition, department staff should periodically review a sample of bills and compare them to source documents, similar to the review currently done for the department's Personal Assistance Services Program. Utilizing the claims analysis tools available from the Quality Assurance Division on a regular basis and following up on identified anomalies could further strengthen the department's financial oversight. Including these financial controls in program activities will increase assurances that services authorized by case management teams and program managers are provided and properly billed.

RECOMMENDATION #8

We recommend the Department of Public Health and Human Services strengthen financial controls for the Home and Community Based Services Waiver Program including:

A. *Requiring detailed waiver program provider billing information.*

B. *Establishing a process to periodically review and reconcile a sample of waiver program provider claims to source documents.*

C. *Using services of the Quality Assurance Division to analyze claims data and patterns of waiver program providers.*

D. *Following up on identified anomalies and unresolved claims pertaining to waiver program services.*

Department of Public Health and Human Services

Department Response

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
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Tori Hunthausen
Legislative Auditor
P.O. Box 201705
Helena, MT 59629-1705

Dear Ms. Hunthausen:

Enclosed is the Department of Public Health and Human Service's response to the performance audit of the Home and Community Based Services (HCBS) Medicaid Waiver program in the Senior and Long Term Care (SLTC) Division.

General Comments

The SLTC staff very much appreciated Kent Wilcox's thoroughness and insight during the audit process. We recognize that it is not easy to learn and review a program which is as complex and multi-faceted as the HCBS Waiver program. The introductory section of the report is an accurate and understandable summary of the program.

The Home and Community Based Services waiver is up for renewal and many of these recommendations will be implemented as a component of the renewal process.

Recommendation #1

We recommend the Department of Public Health and Human services comply with administrative rules that contain enrollment criteria specific to individuals residing in a hospital and if necessary reevaluate existing administrative rules for applicability.

Response: **Concur**

The Department will update ARM 37.70.1408 and department policy to clarify that persons cannot receive services while residing in hospitals or nursing facilities.

Timeline: To be completed by July 01, 2011.

Recommendation #2

We recommend the Department of Public Health and Human Services develop and implement formal criteria for allocating Home and Community Based Service Waiver Program slots among case management teams.

Response: Concur
The Department will continue to allocate slots based on a number of factors including numbers of people on the waiting list in a particular area and a team's ability to absorb additional consumers. Based on the audit findings, the Department will consider ways to more equitably distribute slots based on need.

Timeline – To be completed by July 01, 2011.

Recommendation #3
We recommend the Department of Public Health and Human Services:

A. **Ensure teams submit accurate waiting list information.**
B. **Analyze and utilize waiting list information**

Response: Concur
The Department has continually worked to ensure that teams submit accurate waiting list information. In the course of the waiver renewal SLTC will continue to analyze waiting list management and will establish guidelines relative to the scope of information necessary to maintain a meaningful waiting list and avoid duplication of effort on the part of the case managers. The Department intends to continue analyzing and using waiting list information and working to get accurate waiting lists to make decisions from.

Timeline – To be completed by July 01, 2011.

Recommendation #4
We recommend the Department of Public Health and Human Services ensure annual case management team reviews are completed in accordance with policy and federal agreements.

Response: Concur
Quality Assurance Reviews became a part of the Quality Assurance Management System (QAMS) in March 2009 as part of the enhancements to that system. Two of the changes this facilitated were to ensure that program managers were aware that reviews were due and that the program managers must give approval for closure of a review. Both of these system enhancements were designed to ensure that reviews are completed according to policy. As of this date all of the Quality Assurance Reviews that are due are either in process or have been completed.

Timeline – Completed

Response #5

We recommend the Department of Public Health and Human Services:

A. **Standardize the client satisfaction survey**
B. **Collect and analyze survey responses**

Response: **Concur**
The client satisfaction survey will be standardized and responses will be collected and analyzed by Division staff.

Timeline – To be completed by July 01, 2011.

Recommendation #6
We recommend the Department of Public Health and Human Services define the frequency of periodic reviews of level of care assessments and ensure reviews are completed.

Response: **Concur**
The Department will define the frequency of periodic reviews of level of care assessments and implement a process to ensure reviews are completed as a part of the waiver renewal process.

Timeline: To be completed by July 01, 2011.

Recommendation #7
We recommend the Department of Public Health and Human Services use the Medicaid Management Information System (MMIS) to select a sample of client records for reviews of case management teams.

Response: **Concur**
The Division will utilize MMIS in conjunction with other information for reviews beginning in FY12. After initiating a sample from MMIS some reviews will be customized to ensure that additional factors are considered, such as: consumers from each of the major service areas are chosen, people living in assisted living facilities versus living at home, or lower cost plans and higher cost plans.

Timeline: To be completed by July 01, 2011.

Recommendation #8
We recommend the Department of Public Health and Human Services strengthen financial controls for the Home and Community Service Based Services Waiver Program including:

A. **Requiring detailed provider billing information.**
B. **Establishing a process to periodically review and reconcile a sample of waiver program provider claims to source documents.**
C. **Using services of the Quality Assurance Division to analyze claims data and patterns of waiver program providers.**

D. Following up on identified anomalies and unresolved claims pertaining to waiver program services.

Response: Concur
The Senior and Long Term Care Division has analyzed the required level of billing information. The Division is working with the Quality Assurance Division to determine how best to use their assistance in analyzing claims data and patterns. In addition, financial controls will be strengthened by developing random representative samples and addressing claims review within the Quality Assurance review process.

The Department has followed up on anomalies and unresolved claims identified in the audit.

Timeline – The outstanding corrective actions will be completed by July 01, 2011.

Thank you for all the time and effort your staff put into this performance audit. If you have any follow-up questions please contact Kelly Williams at 444-4147.

Sincerely,

for Anna Whiting Sorrell
Director

CC:
Mary Dalton
Kelly Williams
Marie Matthews
James Driggers